Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

HEALTHTRUST LLC
PO BOX 890008
HOUSTON TX 77289

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-11-4947-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier remitted payment of the pain management program, but not the individual sessions indicating that the diagnosis codes utilized were not related to the work injury. In reviewing the medical notes submitted by two other physicians, you will see wherein the codes utilized were mentioned in their notes as being evident in the patient. "

Amount in Dispute: $1,626.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual maintains its position no payment is due."

Response Submitted by: Texas Mutual 6210 E Hwy 290 Austin TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 6, 2011 through February 22, 2011	90801 and 90806	$1,626.78	$ 0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.

4. 28 Texas Administrative Code §124.2 relating to Carrier Reporting and Notification Requirements
5. This request for medical fee dispute resolution was received by the Division on August 26, 2011.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated February 21, 2011, February 24, 2011, March 22, 2011, March 23, 2011 and April 1, 2011.
   - CAC 151 PAYMENTADJUSTED BECAUSE THE PAYER DEEMS THE INFORMATION SUBMITTED DOES NOT SUPPORT THIS MANY/FREQUENCY OF SERVICES.
   - CAC-193 ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY
   - CAC-219 BASED ON EXTENT OF INJURY (NOTE; TO BE USED FOR WORKERS' COMPENSATION ONLY)
   - 246 THE TREATMENT/SERVICE HAS BEEN DETERMINED TO BE UNRELATED TO THE ETENT OF INJURY, FINAL DJUDICATION HAS NOT TAKEN PLACE
   - 298 ONLY ONE IS ALLOWED PER DATE OF SERVICE
   - 891 NO ADDITIONAL PAYMENT AFTER RECONSIDERATION.
   - CAC97 THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 641 THE MEDICALLY UNLIKELY EDITS (MUE) FROM CMS HAS BEEN APPLIED TO THIS PROCEDURE CODE.

Issues

1. Was the request for medical fee dispute resolution filed in accordance with 28 Texas Administrative Code §133.307
2. Are the disputed services eligible for medical fee dispute resolution under 28 Texas Administrative Code §133.307?

Findings

1. 28 Texas Administrative Code §133.307 (2)(D) if the carrier has raised a dispute pertaining to liability for the claim, compensability, or extent of injury, in accordance with 28 Texas Administrative Code §124.2 of this title (relating to Carrier Reporting and Notification Requirements), the request for medical fee dispute resolution will be held in abeyance until those disputes have been resolved by a final decision of the commission.
2. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution. Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.
3. The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		February 27, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.